Department of Medical Assistance Services
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https://dmas.virginia.gov
MEDICAID MEMO

Last Updated: 03/09/2022

False Claims Act Educational Requirements Mandated by DRA

The purpose of this memorandum is to remind DMAS providers of the staff educational requirements mandated by the Federal Deficit Reduction Act (DRA) of 2005. Specifically, §6032 of the DRA becomes effective on January 1, 2007, and requires entities which receive and/or make Medicaid payments of $5 million or more annually to inform employees about certain fraud and abuse laws, including whistleblower provisions in those laws. Providers will be required to adopt written policies for all employees, contractors, and agents including:

1. Detailed information about the False Claims Act and comparable state anti-fraud statutes, including whistleblower provisions in those laws. In Virginia, the comparable anti-fraud law is the Virginia Fraud Against Taxpayers Act, Code of Virginia Title 8.01, Chapter 3 (8.01- 216.1 through 8.01-216.19);
2. Detailed descriptions regarding the company's policies and procedures for detecting and preventing waste, fraud, and abuse; and,
3. Revisions to employee handbooks (if already provided) to describe the rights of employees to be protected as whistleblowers and restating the company’s policies concerning false claims laws and the company’s internal process for detecting and preventing waste, fraud, and abuse.

The DRA makes compliance with Section 6032 a condition of receiving Medicaid payment, and failure to meet the requirements could result in the forfeiture of all Medicaid payments during the period of noncompliance. Attached to this Medicaid Memorandum is a copy of the State Medicaid Director letter issued by the Centers for Medicare and Medicaid Services (CMS) on December 13, 2006 providing guidance on this DRA provision. Section 6032 of the DRA is presented below in its entirety.

Medicaid Memo:
Special
December 22,
2006

SEC. 6032. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERY.

a. In General- Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended--

1. in paragraph (66), by striking ‘and’ at the end;
2. in paragraph (67) by striking the period at the end and inserting ‘; and’; and
3. by inserting after paragraph (67) the following:

68. provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall--

A. establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

B. include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

C. include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.'.

b. EFFECTIVE DATE- Except as provided in section 6034(e), the amendments made by subsection (a) take effect on January 1, 2007.

CENTERS for MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services 7500
Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

DEC 1 3 iJOS

SMDL #06-025

Dear State Medicaid Director:

We are writing to offer guidance to State Medicaid agencies on the implementation of section 6032 of the Deficit Reduction Act of 2005. This provision establishes section 1902(a)(68) of the Social Security Act (the Act), and relates to "Employee Education About False Claims Recovery."

The following definitions are included in the accompanying State Plan Preprint, although additional guidance in this letter further clarifies the Preprint:

An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for profit, which receives or makes payments, under a State plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than

one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an entity (e.g., a State mental health facility or school district providing school-based health services). A government agency which merely

administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section l 902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

An "employee" includes any officer or employee of the entity.

A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.

It is the responsibility of each entity to establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. Although section

l 902(a)(68)(C) refers to "any employee handbook," there is no requirement that an entity create an employee handbook if none already exists.

An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A}. The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. The Centers for Medicare & Medicaid Services (CMS) is not providing model language, though States may elect to do so.

The provisions of section l 902(a)(68) of the Act must be implemented no later than January l, 2007, except as provided in the section 6034(e) delayed effective date of the Deficit Reduction Act of 2005. To the extent a State determines that it requires legislation to implement this section and wishes to avail itself of the section 6034(e) delayed effective date, it must request through CMS that the Secretary concur with the determination that legislation is required.

The requirements of this law should be incorporated into each State's provider enrollment agreements. Each State must also determine the manner by which it will ensure an entity·s compliance with section l 902(a)(68), which information each State must include in its State Plan along with a description of the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis. Each State shall so amend its State Plan not later than March 31, 2007, or by the end of the quarter in which the effective date of delayed implementation occurs, as described in section 6034(e). CMS may, at its discretion, independently determine compliance through audits of entities or other means. CMS may also review a State's procedures through its routine oversight of States.

If you have any questions on this guidance, please direct them in writing to: Mr. Robb Miller. Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, 7500 Security Boulevard, Mailstop B2-l 5-24, Baltimore, MD 21244 or

Ms. Claudia Simonson, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, Division of Field Operations, 233 North Michigan Avenue, Suite 600, Chicago, IL 60601 or robb.miller!Zi;cms.hhs.gov or claudia.simonson(m,cms.hhs.gov.

Sincerely,

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Dennis G. Smith Director

Enclosure

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cc:

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